Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Elite Healthcare Fort Worth

Respondent Name
American Home Assurance Company

MFDR Tracking Number
M4-15-1543-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am resubmitting the claim for payment for the following reasons: THIS IS NOT A DUPLICATE CLAIM/SERVICE. Treating provider, Dr. Lopez has attached dictations for each date of service. He has outlined key components regarding the patient's office visit. All of this documentation was sent in for reconsideration to the carrier several times. This is an approved case with all other claims being paid in full. Please see attached patient account statement showing all other claims being paid in a timely manner. I'm taking the next step to get the rest of these claims paid and sending all documentation I have to MDR. THESE ARE NOT DUPLICATES. All other claims have been paid at 100%. Therefore, these claims should be paid in full."

Amount in Dispute: $497.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: From initial response, dated 2/17/15: "Please see the EOBs included with the request. Coventry stands by its audit for the disputed DOS. Attached is additional analysis by Coventry for each DOS reduction. The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control. TEX. LABOR CODE Section 413.011(d). Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines…

DOS 3/3/14 – Per documentation received, Coventry stands by the reviews.
CPT 99214 previously denied as : CV: PROCEDURE IS OUTSIDE OF THE NORMAL SCOPE OF PRACTICE FOR THIS PROVIDER TYPE. Adjusted to deny as: CV: THE LEVEL OF E&M CODE IS NOT SUPPORTED BY DOCUMENTATION.
Per Clinical Validation (CV): The CV reduction was upheld on this bill; however the reason for denial was changed. We would recommend allowance at a 99213, however, TX is a no down code state. Therefore, we are unable to make any allowance. In order to meet a 99214, the provider documentation must support 2 of the 3 of the following: a detailed history, a detailed exam and medical decision making of moderate complexity.
The documentation supports a problem focused history, a detailed exam and a low complexity decision making. The documentation is better described as a 99213.
If the provider were to resubmit with a 99213, we would recommend allowance at that rate.

DOS 3/17/14 – Per documentation received, Coventry stands by the reviews.
CPT 99214 previously denied as: CV: THE LEVEL OF E&M CODE SUBMITTED IS NOT SUPPORTED BY DOCUMENTATION.

Per Clinical Validation (CV): The CV reduction was upheld on this bill. We would recommend allowance at a 99213, however, TX is a no down code state. Therefore, we are unable to make any allowance. In order to meet a 99214, the provider documentation must support 2 of the 3 of the following: a detailed history, a detailed exam and medical decision making of moderate complexity.
The documentation supports a problem focused history, a detailed exam and a low complexity decision making. The documentation is better described as a 99213.
If the provider were to resubmit with a 99213, we would recommend allowance at that rate.

DOS 5/13/14 – CPT 99214 previously denied as CV: BILL DOCUMENTATION IS ILLEGIBLE PLEASE SUBMIT WITH LEGIBLE DOCUMENTATION. & CV: PROCEDURE IS OUTSIDE OF THE NORMAL SCOPE OF PRACTICE FOR THIS PROVIDER TYPE.

Per Clinical Validation (CV): We would recommend allowance at a 99213, however, TX is a no down code state. In order to meet a 99214, the provider documentation must support 2 of the 3 of the following: a detailed history, a detailed exam and medical decision making of moderate complexity. The documentation supports a problem focused history, a detailed exam and a low complexity decision making. The documentation is better described as a 99213."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 3, 2014 – May 13, 2014	Evaluation & Management, Established Patient (99214)	$497.52	$165.83

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.203 defines the medical fee guidelines for reimbursement of professional services.
3. 28 Texas Administrative Code §133.240 sets out the procedures for paying or denying medical bills.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 15 – (150) Payer deems the information submitted does not support this level of service.
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 8 – The procedure code is inconsistent with the provider type/specialty (taxonomy).
   - P12 – Undefined as required in 28 Texas Administrative Code §133.240. ASCII defines the code as Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Did the requestor support the level of service for CPT Code 99214 for each date of service as required by 28 Texas Administrative Code §134.203?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the submitted documentation finds that the requestor performed an office visit for the evaluation and management of an established patient.

   The American Medical Association (AMA) CPT code description for 99214 is:

   > Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: **A detailed history; A detailed examination; Medical decision making of moderate complexity**. Counseling and/or

coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family. [emphasis added]

The 1995 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare guideline to determine the documentation requirements for the service in dispute. Required components for documentation of CPT Code 99214 are as follows:

- Documentation of the Detailed History:
  - "An *extended* [History of Present Illness (HPI)] consists of at least four elements of the HPI."
  - "An *extended* [Review of Systems (ROS)] inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems. [Guidelines require] the patient's positive responses and pertinent negatives for two to nine systems to be documented."
  - "A *pertinent* [Past Family, and/or Social History (PFSH)] is a review of the history area(s) directly related to the problem(s) identified in the HPI. [Guidelines require] at least one specific item from any three history areas [(past, family, or social)] must be documented…"

  The Guidelines state, "To qualify for a given type of history, **all three elements in the table must be met.**"
- Documentation of a Detailed Examination:
  - A "*detailed examination* – an extended examination of the affected body area(s) and other symptomatic or related organ system(s)." The Guidelines state, "Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of 'abnormal' without elaboration is insufficient."
- Documentation of Decision Making of Moderate Complexity:
  - *Number of diagnoses or treatment options* – The number of problems, whether the problem is diagnosed, and types of diagnostic testing recommended are taken into account.
  - *Amount and/or complexity of data to be reviewed* – This can include diagnostic tests ordered or reviewed and data reviewed from another source.
  - *Risk of complications and/or morbidity or mortality* – "The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines overall risk."

  "To qualify for a given type of decision making, **two of the three elements … must be either met or exceeded**."

For date of service 3/3/14, the submitted documentation supports that the requestor provided a review of five (5) elements of HPI, a review of one (1) system, and no PFSH. This does not meet the documentation requirements for a Detailed History. The submitted report shows that the requestor included performance and documentation of an extended examination of the affected body area and other symptomatic areas, which does meets the criteria for a Detailed Examination. The submitted documentation supports that the requestor met the criteria for documentation of Decision Making of Moderate Complexity. **Because the documentation indicates that the requestor met at least two (2) of the required key components of CPT Code 99214, the requestor did support this level of service.**

For date of service 3/17/14, the submitted documentation supports that the requestor provided a review of two (2) elements of HPI, a review of one (1) system, and no PFSH. This does not meet the documentation requirements for a Detailed History. The submitted report shows that the requestor included performance and documentation of a limited examination of the affected body areas and other symptomatic areas, which does not meet the criteria for a Detailed Examination. The submitted documentation supports that the requestor met the criteria for documentation of Decision Making of Moderate Complexity. **Because the documentation indicates that the requestor met only one (1) of the required key components of CPT Code 99214, the requestor did not support this level of service.**

For date of service 5/13/14, the submitted documentation supports that the requestor provided a review of three (3) elements of HPI, a review of one (1) system, and no PFSH. This does not meet the documentation requirements for a Detailed History. The submitted report shows that the requestor included performance and documentation of a limited examination of the affected body areas and other symptomatic areas, which does not meet the criteria for a Detailed Examination. The submitted documentation supports that the requestor met the criteria for documentation of Decision Making of Moderate Complexity. **Because the documentation indicates that the requestor met only one (1) of the required key components of CPT Code 99214, the requestor did not support this level of service.**

2. Procedure code 99214, service date March 3, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.5 multiplied by the geographic practice cost index (GPCI) for work of 1.002 is 1.503. The practice expense (PE) RVU of 1.41 multiplied by the PE GPCI of 0.987 is 1.39167. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.799 is 0.0799. The sum of 2.97457 is multiplied by the Division conversion factor of $55.75 for a MAR of $165.83.

   Because the requestor did not support the level of service for CPT Code 99214 for dates of service 3/17/14 and 5/13/14, no reimbursement is recommended for these dates of service.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $165.83.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $165.83 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	March 19, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.